

# LFS Membership Program

## **Plan Features and Highlights**

Easy to use                      No waiting periods  
No limits on use                No claim forms to complete  
Group rates available        LFS is not a dental insurance plan

**Silver Pan includes:** One year dental saving plan: 35-50% off on all dental work.

Individual Member Fee: \$109 Family Member Fee: \$167. (Can add up to 4 family members Adults & 2 Children)

**Gold Plan: Individual fee of \$416 includes:** One year dental saving plan: 35-50% off on all dental work.

Plus 2 Cleanings and X-rays per year.

## **Plan Summary**

The cost of health care keeps rising making it more difficult for you to pay for the essential care you and your family need to stay healthy. However, because minor health care issues can lead to serious and more expensive problems if left untreated, it is best to not skip preventative care or delay necessary

*DR. SONIA GIORDANO, DMD*

**50 East Main Street Little Falls, NJ 07424**





## LFS MEMBERSHIP PLAN APPLICATION

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Spouse, Family member to be included in coverage:

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Name: \_\_\_\_\_

Please indicate the plan you have chosen below:

**Silver Plan:** One year dental discount plan: 35-50% off on all dental work.

Individual Member Fee \$109.00\_\_\_\_\_

Family Member Fee \$167.00\_\_\_\_\_ up to 4 Family Members.

**Gold Plan:** One year dental discount plan. 35-50% off on all dental work.

Plus 2 Cleaning and X-ray per year. Individual Member Fee \$416 \_\_\_\_\_

Method of Payment:

\_\_\_\_\_ Check (Please make check payable to Dr. Sonia Giordano, DMD)

\_\_\_\_\_ Visa \_\_\_\_\_ Master Card \_\_\_\_\_ American Express \_\_\_\_\_ Discover

Credit Card# \_\_\_\_\_ Expiration Date: \_\_\_\_\_

**LFS Dental Saving Plan:**

I hereby apply for membership in this dental saving plan for myself and others named on this application form. I agree, for myself, and any other listed, to abide by the rules and regulations of the plan. I understand that all discount rates apply only to payments made in full at the time of service. I further understand that my coverage and benefit may be affected by my failure to provided complete and accurate information. I will promptly advise Dr. Sonia Giordano of any changes in this information.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

Bring, Mail or Fax this Form to Dr. Sonia Giordano's office: (Fax, email and office address are below)

Phone: 973-256-2245 Fax: 973-256-8272 or email us at dctrgiordano@gmail.com

Address: 50 East Main Street. Little Falls NJ 07424